# The Bulletin

## OF THE

# South Indian Medical Union.

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## PUBLICITY SECTION.

# SOUTH INDIAN MEDICAL UNION,

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It is regretted that the April issue of the Bulletin has been unavoidably delayed and the Publicity Section offers its sincere apologies.

Surely, you have a friend who is interested in the progress of Medical Relief and the Profession. May we send him a copy of the Bulletin? Will you kindly let me have his address?

Some copies of the Bulletin are being returned by the Post office with the endorsement "left station—no instructions." Will ALL MEMBERS OF THE MEDICAL PROFESSION kindly send us their present address and any future change. WE DO WANT TO BE IN TOUCH WITH THEM AT ALL TIMES.

T. Krishna Menon

For PUBLICITY SECTION.

**BULLETIN**

OF THE

**SOUTH INDIAN MEDICAL UNION.**

APRIL 1931.

# THE MENACING CLOUD

THE QUESTION as to whether or not State Medicine would prove satisfactory is well answered by Dr. Wingate M. Johnson, writing in the March number of the Atlantic Monthly. Dr. Johnson says, " If the day ever comes when the STATE takes over the health of its subjects, individually as well as collectively,—God pity the patient !" To this sage observation let us add, " God pity the doctor !" And to complete the picture, we shall paraphrase Tiny Tim: " God pity us every one. "

The so-called pessimists in our ranks (and may their tribe increase) see the cloud of State Medicine, which was, at one time, ' no bigger than a man's hand " rapidly assuming gigantic proportions. The optimists, with lifted brows insist that the cloud does not exist. This is one of the rare cases where the optimist, and not the pessimist, wears the smoked glasses.

To ignore the possibility, nay probability, of State Medicine, is to emulate the mole. And that is being pretty hard on the mole. Any one with an ear to the ground (and our medical Pollyannas should be in a good position, inasmuch as they are prone most of the time) may hear the preliminary skirmish which presages the real battle shortly to follow.

The latter will end in one of two ways. Either the reformers will be victorious and the doctors will be slaves; or the doctors will be temporarily victorious and the reformers will be girding their loins for a new onslaught. Then, and not until then, will the greater part of the profession realize that eternal vigilance is the price of medical independence; and that such vigilance must be active—not passive.

We must fight fire with fire. We can't kill bears with toy pistols. We can't catch tarpons with bent pins. And by the same token, we can't down paid reformers with platitudes.

It is high time that we begin to do some first-class viewing-with-alarm. What we need is an eye-opener to awaken us from our lethargy. The burden of carrying our colors is resting on the shoulders of a few. It is absolutely imperative that we face the incontrovertible facts and actually perceive the contumacious vapor which is rolling forward to obscure our individuality stifle our initiative and strangle our self-esteem !

THE TOLEDO ACADEMY *of* MEDICINE—BULLETIN.

## General Notes.

It is very gratifying to note the increased interest taken by the lay public in Medical Relief. For the first time, Medical Budget has had an attention befitting its importance in the local Legislative Council and our congratulations are due to Diwan Bahadur Arokiaswamy Mudaliar, M.L.C., and Mr. V. T. Arasu, M.L.C. on their exposition of the medical needs of the country. Mr. Arasu in the short period he has been in the Council has already made a mark by his study of the subject and fearless denouncement of the evils that have crept in the department.

*  *  *

We ourselves were surprised at some of the points raised. District medical officers who live thirty miles beyond headquarters, medical officers with their vows of silence, others who are on the active list and draw full working pay whilst claiming compensation for permanent injury and consequent inability to work might well be creations of that great Savoyard, Gilbert. But for Mr. Arasu's assurance that he speaks on first hand information gained in the course of his League of Youth work, we ourselves would have been constrained to doubt them. If things are as they have been depicted to be, they hardly speak well of the tone of the medical services.

*  *  *

The Retrenchment Committee has become a settled fact. A special Retrenchment Officer has been appointed and suggestions from the Departmental Chiefs have been called for. We wonder if other agencies will be allowed to lay their evidence before the Committee. Experience has shown that Bureaucracy is the same in all countries and that, honestly it may be, it believes that it is always undermanned. It would be desirable if other evidence is called before the Committee comes to its final findings. But what happens whenever such committees meet is that a few peons or clerks are lopped off and some minor allowances suspended. It would be here interesting to enquire how it worked on a previous occasion. The then illpaid assistant surgeon (his salary was Rs. 100 per mensem) had his allowance of Rs. 30 per mensem cut but a kind officer came to their rescue and a number of them having lost their thirty rupees were nominally tacked on to another institution and were there provided with an allowance of Rs. 125 per mensem. Thus retrenchment works.

*  *  *

It was the late Lord George Hamilton, when he was the Secretary of State for India, who wrote that "the medical needs of a growing country can never be adequately met by an increase of the administrative services and that the *only* method would be by increasing and fostering a healthy Independent Medical Profession." The Governments in India, though they agreed to this view, could hardly be accused of having acted in the spirit of the above, except in a few

places. We ourselves know the difficulties put forward in this Presidency and the obstacles placed in the way of the members of the Independent Medical Profession. Thanks to the generous policy initiated by the late Raja of Panagal and maintained by his successors and thanks to the successive Surgeon-Generals who loyally carried out this policy, the machinations of the vested interests, especially of the indigenous variety, have been frustrated. With a minister who was the *chela* of the late Raja Saheb, and a Surgeon-General with the reputation of Major-General Sprawson at the head of the department we feel sure that there is no cause for anxiety and the justice of our cause will win.

* * * *

A Medical Society when it departs from purely scientific subjects and launches into Medical politics has to restrict its membership. It cannot absorb all the classes into one association for the interests of each are bound to clash. No better example could be quoted than that of the Indian Medical Association of Calcutta. The Indian Medical Association claims to represent the Indian Medical Profession; more so it claims to represent and speak for the *Independent* Medical Profession of India. But its membership is open to all medical men in India, service and non service, practising or otherwise. In many places its chief executive is the local Civil Surgeon. The result has been that it has become another mouthpiece for the Services. It wants Indianisation of the Services. It has not considered whether paid medical Services as at present constituted are essential for medical relief. Replacement of Mackenzie by Mohanlal seems to be their only contribution towards medical reform.

A provincial service association could not have put forward its views better than Khan Bahadur Dr. Barucha, Chairman of the last annual Conference, in his opening address. We wonder whether he is one of the Bombay Medical Service. In marked and refreshing contrast is the presidential address. Dr. Jivraj Mehta, a distinguished Member of the Independent Medical Profession of Bombay, very rightly lays stress on the replacement of the *paid* Services by *Honorary* workers in the hospitals, restricting the paid men to Preventive Medicine.

* * * *

Complaints about the working of the Rural Medical Scheme seem to be increasing. Whilst it may be attributed partly to ignorance of the government orders and mainly to a feeling—to which, one is sorry to note, a large number of Rural Medical Practitioners have contributed not a little—that the Rural Medical Scheme is a fourth *Service* and is meant as a temporary stop-gap pending a billet in other services. We have heard of instances where some of these practitioners have requested the conversion of rural dispensaries into local fund dispensaries. Requests for buildings, office equipment and staff, and for even the necessary instruments which one invests in before settling down in practice are too common and are hardly

conducive for the maintenance of independence in their dealings with the local board authorities. It is no wonder that when such is the attitude of some at least of them that the local board presidents consider them as local board servants and deal with them as such.

* * *

But none of these can justify the actions of some of the local board presidents in their dealings with the Rural Medical Officers. The incident at Kaup is still fresh in the minds of the profession. The latest complaint comes from the Rural dispensary at Avalurpet (South Arcot). The Rural Medical Officer, mark you! is a practitioner induced to settle down there and subsidised to look after the sick of the village. His subsidy comes out of provincial funds. But, in spite of this, he is ordered to leave his area, ignore his patients and neglect his legitimate work by the local board president. Why? To do cholera inoculation at a distant village which is the legitimate province of the Public Health department. One would have thought that this young doctor would have been compensated for loss of practice and commended for his zeal. But the local board Satrap has decided otherwise. He has mulcted the doctor of his subsidy for the period he was away from the station.

* * *

It is high time that the irregularities that have crept into the scheme are removed and the spirit with which the scheme was inaugurated restored. We would request the Government to appoint a committee, with adequate representation of the Independent Medical Profession, to go over the entire scheme and re-model it in the light of past experience.

* * *

We have been informed that a certain head of the medical department was rather strict on the ethical standards of the members of his department and that as a result of this a young Assistant Surgeon was compelled to remove his office from the premises of a dispensing chemist. In another instance a junior member of the Madras Medical Service was advised to live away from his joint family as one of the other members happened to be a dispensing practitioner. We have been asked if this rule is applicable only to Assistant Surgeons; whether Civil Surgeons are exempt from its operations as in, at least, two open dispensaries in Madras city, senior officers of the latter category may be seen conducting their private practice.

* * *

We congratulate Dr. K. C. Paul, M.D., on his success at the medical examinations and the well deserved Doctorate of Medicine he has earned. We hope that many more of our members will emulate Dr. Paul's example.

* * *

Speaking of these higher examinations we have repeatedly represented to the Government, the disabilities of private practitioners. As things stand

now it is next to impossible for a medical graduate to get a scholarship. His conferee in the services is given the benefit of deputations with full pay and other allowances, study leave and a guaranteed income at the end of it. We do not ask for all these. A number of scholarships, both local and otherwise would be a boon to private practitioners and a distinct saving to the State. We are sure that they in return would be willing to serve in selected State hospitals in an honorary capacity and would thus enable the government to release money now paid in salaries. We understand that the Surgeon-General's sympathies are with us but that the financial stringency stands in the way.

In what better way could *retrenchment* be effected than by well qualified practitioners replacing the salaried services.

## Medical Services and Private Practice.

In the recent session of the Madras Legislative Council, some of the speakers referred to the undesirability of allowing the members of the various paid medical services of the Government to busy themselves in remunerative private practice. This question has been engaging the attention of the public and the independent profession for almost a generation. The late Dr. T. M. Nair never lost an opportunity of drawing the attention of the Government to this evil. A reference to the back numbers of 'the Antiseptic' would show that Dr. U. Rama Rao has been constantly referring to this question. With the access of larger numbers to the ranks of the independent profession, the ill effects of this pernicious practice are being increasingly felt by medical men who are outside the service circle. In spite of all criticisms and representations, the evil has been allowed to persist; nay, it has grown to such proportions that we consider it useful and necessary to review the whole question of private practice as carried on by members of the paid services.

It is being asked on all sides whether it is in the interests of the public and whether it is helpful to the maintenance of the correct 'tone' of public service if a paid official of the State be allowed to take up private work to increase his earnings. In no department of the Government, expect the medical, is this privileged procedure current. One of the arguments, if not the main argument, advanced in justification of this exception used to be the indispensability of the Government medical men to the public when expert and specialist medical help was needed. And they seriously claimed to be the best available medical men, specialist and otherwise, at least in this province. If this claim were true that people have to look up to the men in service for competent medical help and that the men outside the services were inefficient, then it would be obvious that such an unsatisfactory state of affairs would be intolerable and a Government that perpetuates such conditions would stand easily condemned. Frankly, we do not believe in this almost preposterous claim. The Government does not allow its expert engineers to be engaged privately even by the richest and most influential of citizens to advise them on irrigation or buildings. An alleged murderer might believe that a particular judge is the best lawyer and that he alone might be able to save him from the gallows. But the Government does not on that score, allow the judge to be *feed* for the defence. We suspect that the Government medical men are

now getting a little less confident of their claim to be the quintessence of medical knowledge, though we still come across members who proudly question their lay friends if they could name any one outside service ranks as competent as physician A or surgeon B. To the annoyance of service members, the public is rapidly realising the untenability of their pretensions. They are therefore shifting their ground from that of indispensability to that of being only part-time officials. This is indeed a very convenient conception of their duties. It combines the privileges of public service with the freedom of private practitioners. Unfortunately for them, they are not quite certain of their new ground. They seem to be in divided mind about this novel idea. A little time ago there was a stir in the medical world when someone in authority suggested that medical men were expected to put in a daily minimum of five hours' work in the institutions. This does not square with the contention of part-time service. Further, when we compare the scale of pay of the medical services with that of other departments, there is hardly anything to justify this contention. The Madras Judicial Service, the Engineering (P.W.D.) Service and the Revenue Service have all of them scales of pay very much alike what obtain in the Madras Medical Service (provincial). None of the former is treated as part-time service; we therefore fail to understand why the medical service alone should feel and why it should be encouraged to feel that it is a part-time service. In the higher medical services, we find that officers like the Chemical Examiner to the Government of Madras, the Superintendent of the Medical Stores, Directors and other officers of the Research Department are not privileged to practise and are treated as full-time Government servants. Some of these men receive an allowance of a couple of hundreds of rupees in addition to their regular service pay. But that is not in compensation for loss of private practice. In many cases their pay is similar to that of men in the medical department. This new found plea of part-time service is unreasonable and unconvincing and it does not bear even the gentlest of scrutiny.

Old habits die hard and the public which has all these years been led to believe that superior talents and specialist experience are the monopoly of the service medical men, advocate as a compromise that these medical men should be prevented from having general practice, but should be available to the public in the high role of consultants. The Services themselves would condescend to give up some of their privileges if they be vouchsafed this outlet for their eminent intellectual and professional skill. From what we see of so-called consultant practice, we fear this apparent restriction would be worse than the existing freedom. Some officers of the medical department who were debarred from any private practice were, about twenty years ago, allowed at their repeated request to engage in consultant practice. How this privilege was used and carried out, not certainly in the spirit, though probably strictly correct to the letter, is well remembered by some of the senior men in service now.

Finally, it is urged that if men engaged in special branches of medicine are allowed to practise their own speciality without dabbling in other spheres, this abuse of the privilege of private practice would disappear. We do not agree with this contention. Among the earliest of English physicians was one John of Gaddesden. He was born in 1280. He was the author of a famous compilation which was in common use over Europe for probably over two centuries. It is said of him that he was singularly free from any-

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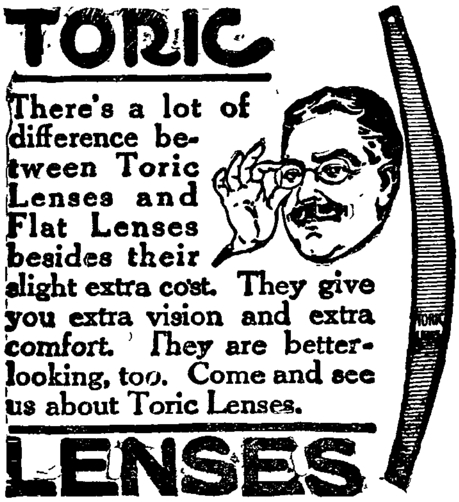


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thing that could be described as false modesty. He dabbled in surgery, was willing, if he were paid for it, to draw his patients' teeth, cut their corns, and even kill their lice. He condescended to instruct his lady patients, if they were rich, even in perfumes and hair washes. Six centuries later, we find in Madras his counterparts. It is nothing unusual to find men supposed to be bacteriological consultants examining patients and issuing wound certificates. One may come across radiologists writing out prescriptions of carminative or salicylate mixture for the benefit of their faithful patients. There is no need to catalogue illustrations. We are sure that our readers would find no difficulty of recalling to their mind scores of such examples.

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**edical Association Annual Conference, 1931.**

WELCOME ADDRESS

BY

Khan Bahadur Dr. E. S. Bharucha, L. M. and S., F. C. P. S., Chairman, Reception Committee.

Ladies and Gentlemen,—It is my very pleasing duty this morning to extend to you brother and sister delegates and all other visitors, a very cordial welcome on behalf of the Poona Branch of the Indian Medical Association to this our annual gathering of the Association, which at our invitation has on this occasion come to be held in our ancient and historic city of Poona.

This is the 7th annual gathering of our Association, which is still in its infancy. Our own branch has not yet seen the end of a single year's work. It is therefore not without a certain amount of hesitation that we took the liberty of inviting you amongst our midst. We hope that you will have a good time and that with our united efforts and God's blessing this gathering will be a success.

Our Association has come into existence not a day too soon. It has as its goal to become a power in the country in all matters professional even as the old and already well-established association in England, the British Medical Association. Already in its short career it has done no little service to the profession by taking a dignified part in the two burning questions of the day, *viz.*, the non-recognitions of Indian degrees by the General Medical Council in England and the important question of the location of the Research Institute not in the out of the way hill station, like Dehra Dun but in the midst of and near important centres for medical education. This branch of ours also considered the latter question at one of our meetings and though our action may appear presumptuous to some of you we consider few places in India are so well fitted for the purpose as Poona whether taken from the point of view of the vicinity of large institutions to supply material for research or from the point of view of climatic conditions or of the distance from social distractions.

Ladies and Gentlemen, great and important changes are pending in the administration of our country. Full provincial autonomy and even a considerable amount of responsibility in the central government are practically assured. It is but meet and proper that in such changes in policy as may be brought about both in the Central and Provincial Governments, the antiquated policy of medical administration must be thoroughly overhauled. And our Association both at the centre and in the various branches will have not only to keep a keen watching eye on all such changes but they will have to be ready with considered schemes of

their own appropriate to the needs of each province and submit them in time to the proper quarters before any hasty step has been taken. The medical policy as existing at present though antiquated has in its time certainly done great service to the country. It would therefore be appropriate to first take a bird's eye view of the growth and development of medical education and relief during the past. I would here ask you to note that all my remarks on the subject will be referring mostly to conditions prevailing in this Presidency only.

### History of Medical Education.

The present medical policy in the Presidency may well be considered to have begun somewhere about the middle of the last century with the establishment of the Grant Medical College and a little later of the University of Bombay to which the College was affiliated. Previous to this medical relief was in the hands of the officers of the Military Department, under whom a few candidates were being trained in the elements of medical science. After passing a very short and elementary course of study the candidates served in the military department mostly as compounders and dressers. There was hardly anything like a civil medical relief policy until after the establishment of the College. Medical education in the college in the early days was imparted both in English and the vernaculars. Those trained in English, received a full course of study according to the standards prevailing in those days and at the end of their course they got degrees or diplomas entitling them to practise all branches of medicine independently. On the other hand those trained in the varnaculars received only short course of three years' training in most instances at Government expense, after which when qualified they were employed by Government to carry our subordinate work in the district under the designation of Hospital Assistants. Both classes of medical practitioners were necessarily in the early days quite few and not proportionate to the total wants for medical relief in the Presidency. Later on with the advance of higher education more and more men began to take advantage of the University course and some of them were employed by Government in the districts having a seemingly superior status to that of the Hospital Assistants under the designation of Assistant Surgeons. They however were ineligible for district appointments and always remained subordinate to Civil Surgeons who were members of the Indian Medical Service.

Neither were the prospects of Hospital Assistants any the brighter. A Hospital Assistant in those days lived and died in that humble capacity, though he as subordinate officer in most instances bore the brunt of the work in the districts. Such was the state of affairs at the beginning of the century. Needless to say it caused a great deal of heartburning and disaffection in both these classes of officers. The Hospital Assistants could not remain long silent, they started an Association to ventilate their grievances and seek redress, demanding improvements both in their course of study and status. As a result the course of study was increased from three to four years. Later on with the establishment of the College of Physicians and Surgeons, Bombay, the medical schools got affiliated to that body and the pupils qualifying were given diplomas of license from the College. They next demanded a change in their designation which was consequently altered to that of Sub-Assistant Surgeons. Not content they still agitated to have their course of study increased in order to enable them to get to the status

of Assistant Surgeons and it is only recently that the College of Physicians has resolved to increase the course from four to five years revising their entrance qualifications as also the curriculum of study.

All this time the Assistant Surgeons remained passive relying more on their superior qualifications and attainments and expecting Government to ameliorate their condition. They had no Association of their own to speak out for them. The Indian Medical Officer cared little as to what happened to them. After many individual memorials at the beginning of the century Government released in their favour four of the least important Civil Surgeoncies from the cadre of the Indian Medical Service with the anomolous condition that their designation should still remain as Assistant Surgeons and the service of these officers be restricted to those districts only. This policy still remains, the same on paper at least so far as their status is concerned. During the Great War as most of the I.M.S. officers had to revert to military duty—they being essentially officers of that department as many as nearly three-fourths of the Civil Surgeoncies were handed over to the Assistant Surgeons as a temporary measure and even at the present day a certain number of the officers of the Assistant Surgeons class continue to hold these posts but only in an acting capacity. How well they rose to the occasion and filled the gap created by the redrafting of the I.M.S. Officers to the Military Service is well known to you all as can be seen from the annual reports of the Surgeon-General.

## The Present Position.

The profession is now divided into four distinct classes of men—each with a definite interest of his own, *viz.*, the Indian Medical Service, the Assistant Surgeons of the graduate class, the Sub Assistant Surgeons and lastly that large class of medical men working independently whether Europeans or Indians, University graduates or licentiates. These conditions were not there when the medical policy was first conceived and started in the last century and it was inevitable that in the absence of qualified men in those days the whole field should have remained practically unchallenged in the hands of the Indian Medical Service officers. With the growth of the profession and the liberal supply of Medical men—thanks to these same officers of the Indian Medical Service who initiated their growth it is but reasonable to expect that there should have arisen in the country with the general cry of Indianisation all round a demand also for Indianisation in the higher grade of the medical services. An entirely new scheme appropriate to the present requirements is thus most urgently needed. In any such scheme consideration of the facts stated by me above should be given due regard.

With the inauguration of Provincial Autonomy the recruiting of medical officers for each Province will rest necessarily in the hands of the Minister in charge. A competitive examination for all appointments in the Provinces will be the best solution in that case. It will not only ensure the selection of the best men but it will be a true incentive for ambitious persons to continue to advance in the profession. Each Province of course will have its own competitive examination and I would go further as far as possible to give preference to distinguished candidates from our own medical colleges and schools to those with foregin diplomas. For that purpose a complete revision in the entrance qualification, course and curriculum in the different Provincial schools will have to be carried out. The College of Physicians and Surgeons of Bombay has already taken the first step in that direction by

increasing the course of study in the Provincial Medical Schools in this Presidency from four to five years. That is a step in the right direction and deserves to be copied without delay by similar bodies in the rest of the country if not already carried out. A very urgent need is the standardisation of all medical education and bringing it on a level with that of the minimum university course. That would necessitate a further consideration of changes in the entrance qualification as well as the course and curriculum.

The standard to be enforced should be the same in all the different schools in the country and, also the staff should be selected from the most distinguished members of the profession. This achieved there should not exist any difference between the university graduates and the college diplomates to sit for the same competitive examination as actually is the case with the examination of the I.M.S. candidates—who sit on equal terms for competition be they mere diplomates of the Royal Colleges or graduates of Universities. The immediate concern should be a thorough overhauling of the course, curricula, staffs, etc., of our existing teaching institutions and enforcing a minimum standard of qualification from all. I would suggest, that our Association both at headquarters and especially in the Provinces should take up this question in earnest for consideration and draw out a scheme to revise the present medical policy on the lines suggested by me, if my view is accepted that the paid medical service should be retained. That done it may be presented to the proper authorities with a recommendation to appoint a representative committee to consider and report on it—taking evidence if necessary of persons best fitted to advise. Even if my view of retaining the paid medical service be considered not in conformity with the considered view of a majority of our colleagues—the Association will have to take early step to advise Government with their opinion for any alternative scheme for their consideration and necessary action. Whatever view be taken there should be complete unanimity in every province if any weight is to be attached to the recommendations of our Association.

MILITARY MEDICAL SERVICE.

Ladies and Gentleman, I should here like to say a few words regarding military medical service. The military medical service in this country as you are all aware is divided into the R.A.M.C. and the I.M.S. services. The former is entirely meant for British Troops and the latter for the Indian Troops. I do not propose to say anything regarding the former, for as long as the British troops continue to remain in India they will necessarily be subject to rules and regulations of that service all over the Empire regarding the superior medical staff. But the case of that class of officers known as military assistant surgeons stands on a different level. They, as you know, are recruited in India and educated at the expense of the Indian Government in Madras and Calcutta and come entirely from the Anglo Indian community. Some of these are transferred to the Civil Medical Department like the I.M.S. Officers, after serving certain periods in the Military and often hold important and coveted places in that department. The ineligibility of an Indian to this service and the transfer of these officers to senior civil medical posts often in supercession to Indians has always been a grievance of great magnitude especially in Bengal and other provinces in the North and it behoves our central Association to take up this subject for consideration at an early date. Beyond that I do not think it would come within our province to say anything regarding the

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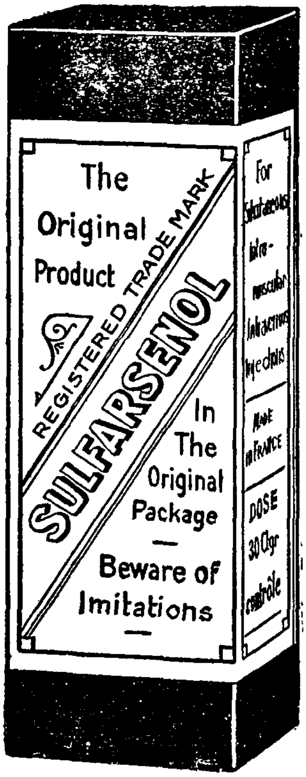


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R.A.M.C. service. It is different, however, when we come to consider the subject of the I.M.S. service. You are all aware that the question of Indianisation of the Indian army and the reduction of army expenditure has been discussed time and again by the Central Legislature. To my mind a very considerable reduction can be effected if a reorganisation of the I.M.S. for military service is seriously taken in hand. I would also suggest that all recruiting for I.M.S. officers should take place in India by a competitive examination held in some central place as Delhi or Calcutta or Bombay. Here also, I need not say, the vested interests of those already in service should be adequately safeguarded.

### General Medical Council's Action.

I shall now briefly refer to a question which has engaged the attention for us all, especially the Indian medical profession during the past year—I mean the high-handed action taken by the General Medical Council to withhold recognition by the Council of all medical degrees of Indian Universities. Much has been said and written on the subject during the past year. This Branch, in common with the rest of Indian medical profession, has passed a resolution condemning the ill-advised and hasty step taken by the General Medical Council. No question of medical policy has received such a unanimous support from the Indian profession of all grades as this decision of the General Medical Council. It has been universally condemned from one end of the country to the other. Some have called it a gratuitous threat, others consider it an unwarranted insult. and our friend Dr. Jivraj has very appropriately described it as a blessing "not in disguise but without disguise." I for one, am entirely of that opinion with him for it has shown the intentions of the Council in their true colour. The resentment created in the country against the insolent action of the General Medical Council has been attributed by some persons to the "distrust" prevailing in the country against all intentions of Great Britain in her dealings with India.

Just consider how patiently the Indian profession and the universities have borne with the dictatorial terms of the Council. Wherever they found the necessity to revise and alter the course and curriculum of university training consistent with their dignity to satisfy the requirements of the General Medical Council they have carried them out in deference to the wishes of the Council and for their own satisfaction they have raised the standard of their affiliated colleges and brought them in line with that prevailing in Great Britain. They even submitted to the humiliating conditions of getting their examinations supervised by the representatives of the General Medical Council. And when instead of "a single autocratic commissioner of medical qualifications and standards" as proposed by the General Medical Council—the Government of India made the very reasonable proposal to appoint an all-India Medical Board, specialists in their own subjects, *viz.*, medicine, surgery and midwifery respectively for the purpose of carrying out inspection and reporting on the standard of medical education and examinations, till a bill for establishing an Indian Medical Council was taken in hand, that proposal was summarily rejected by the Council as not supplying "the necessary guarantee of sufficiency." Surely, ladies and gentlemen, that was the last straw and no self-respecting Indian graduate can with all the best of intentions satisfy his conscience with a belief that the decision of the Council was due to the prevailing discontent in the country. Optimistic as I have always been—I

see in this unwise action of the Council a true beginning of medical Swaraj in India. It has awakened the Government of India from their lethargy and every effort is being made to get the Indian Medical Council Bill passed through the Indian Legislature at an early date. We have been told that the Bill is practically ready—but is awaiting the opinion of the local Governments and will be brought up for consideration during the next Simla session. I do hope that all medical societies and unions in common with our Association and its branches will be given an opportunity to consider its details before its final presentation to the legislature.

INDIAN MEDICAL COUNCIL BILL.

In the absence of any reliable information regarding the contents of the Bill—it would be premature to make any criticism at this juncture. But great care will have to be taken to safeguard the interests of the two classes of parctitioners that exist in the country, *viz.*, the university graduates and the licentiates. This compartmental division of our professional men in India into Sub-Assistant Surgeons, Assistant Surgeons and so on is described by Col. Gidney "to be wrong in principle and practice." Already there are runours—I do not know on what foundation—that the registration on the All-India Medical Council is to be restricted to the University graduates only. If there is any truth in it, I fear great dissatisfaction will be the result. It will vitiate the principle about which I have spoken above in detail to standardise all medical education and to bring all medical men on a uniform level as in Europe. I am quite aware of the difficulties that are ahead. The bill has been brought forward in reply to the action taken by the General Medical Council and the minimum qualification for registration will have therefore to be the same as that existing in the case of British diplomas and degrees. This condition unforunately places the present licentiates in a very difficult situation indeed. But there should be no objection in the beginning to include amongst the university graduates those medical men who have passed the membership or fellowship tests of the College of Physicians and Surgeons, Bombay, and all such tests elsewhere in the other parts of the country, they having already satisfied all the requirements necessary for the university tests—except that instead of their having taken their whole course in colleges affiliated to the Universities, a part of their education was received in Provincial schools. Further I would suggest that provision be made in the new Bill to include later on after the changes in the course and curriculum suggested by me above are adopted in our provincial schools, all medical men qualifying under those conditions. Unless some such provision is made in the New Bill, I fear, we shall be perpetuating the same bureaucratic policy that has existed so long, but under different circumstances and the old cry "of a highly qualified junior" not being able "to aspire to the highest posts" will be repeated with greater force.

My ideal is to produce a strong united body of medical men throughout the country so that they can stand against any such attacks as have lately been made on them by the General Medical Council relying on their own merits. If need be, we can then even ignore the non-recognition of our men by the Council. And why after all, should we be so eager to be recognised by the General Medical Council and thus indirectly endorse the assumption of superiority of that body on us. Medical science is the same all over—there is enough material and more for teaching in the country.

**BULLETIN**

OF THE

**SOUTH INDIAN MEDICAL UNION.**

**APRIL, 1931**

## Some Common Surgical Conditions of the Rectum and Anus.*

P. Govinda Rao, M.B., B.S.,

*Honorary Assistant Surgeon, Government Royapuram Hospital.*

*Anatomy.*—Rectum commences in front of the third sacral vertebra and ends 1½" below and in front of the tip of the coccyx opposite the lower part of the prostate in the male and the lower fourth of the vagina in the female. The valves of Houston on internal surface, spiral horizontally situated folds three in number are the only structures which need be mentioned as they at times cause a little obstruction to the passage of a sigmoidoscope. Anal canal about 1" long leading downwards and backwards to the anal orifice, forms an angle of 90° with the rectum. On each side are the ischiorectal fossa, in front the membranous urethra in the male, the perineal body in the female and behind the anococcygeal body. The longitudinal m of the large intestine forms a thin investment here, and the circular m. fibres are thickened to form the internal sphincter. The anal canal shows 8 or 9 vertical folds composed of mucous membrane and muscularis mucosae (columns of Morgagni). These columns, broader below and tapering above, are connected at their bases by a zigzag line a little above the anus. This line is the line of Hilton and is said to indicate the fusion of hind gut and proctodaeum. Between the columns of Morgagni are the sinuses of Morgagni which are guarded below at the level of the line of Hilton by the anal valves. These sinuses as well as valves are better marked posteriorly.

The external sphincter, a subcutaneous muscle, supplied by the fourth sacral nerve, takes its origin from the tip of the coccyx and surrounding the anus is inserted into the central point of the perineum. Two deeper muscles, the levator ani and the coccygeus help to support the bowel. The levator ani forms the medial boundary of that very important fossa, the Ischiorectal fossa. This latter fossa, bounded medially by the anal fascia covering the levator ani, laterally by the pelvic fascia covering the obturator internus muscle, posteriorly by the sacrosciatic ligament and the gluteus maximus muscle, and internally by the internal sphincter is continuous with the subcutaneous fat, thus explaining the easy spread of infection from the subcutaneous tissues into the fossa.

*Blood vessels.*—*Arteries.* The inferior mesenteric, the internal iliac and the pudic vessels supply the rectum through their haemorrhoidal branches which communicate with each other freely.

*Veins.* The veins are valveless; in each column of Morgagni we find a plexus of veins and from the upper of each column one or more veins proceed up and after a variable distance perforate the muscular coat and join the superior haemorrhoidal veins. In the perianal skin are a number of radially arranged veins communicating with one another by a circular vein, these being the radicles of the inferior haemorrhoidal and middle haemorrhoidal veins. These two groups of veins anastomose very freely in this region and thus a connection is established between the portal and systematic circulations.

*Examination.*—Inquiry should be made in every case for the history of pain, haemorrhage, discharge, fre-

* Read before the South Indian Medical Union.

quency of bowel action, shape, size of the motions and the presence of any swelling at or near the anal margin.

*Visual examination.* — Different positions are adopted in different cases: (1) Left lateral or the Sim's position is useful for ordinary purposes and specula can be used also in this position. (2) Knee elbow position, very comfortable for examination but the patient can't keep in that position for a long time. (3) Exaggerated Lithotomy position (adopted for all rectal operations) with the buttocks jutting beyond the table, a sand bag might be used beneath the buttocks if necessary and (4) The standing position in which after the finger is introduced, the patient is asked to strain brings the higher parts of the rectum within reach.

*Digital Examination.*—The skin outside is carefully observed, the anus is separated to see if there is any fissure between the folds and then the finger lubricated with vaseline introduced slowly with the pulp of the finger pressing upon the anal margin. Digital examination is quite enough for most purposes as almost all lesions are to be found within the first ¾" of the anal margin.

*Speculum Examination.*—The Lockhart Mummary speculum is the speculum of choice, no anaesthesia being necessary for its introduction; the only precautions being not to turn the speculum inside the rectum but to take it out every time and put it in a different position.

*Antiseptic technique and diet in rectal surgery.*—Castor oil is given on the morning of the day before operation, the same evening the patient gets a soap and water enema, dose of Tr. opium (m.xv) is given as a draught at night. Another enema is given the morning of the operation day to be repeated if not clean. The skin can be prepared with Tr. Iodine or picric acid and the patient need not be shaved in uncomplicated piles operations. Before commencing operation it is better to irrigate the whole area with a douche of lysol (one ounce to the pint.)

On the third day after the operation, patient gets an ounce of castor oil and paraffin could be given every night after that, until healing is complete. Retention of urine frequently occurs on the first day and catheterization might have to be done. Best results are obtained in rectal surgery only if the patient is confined to bed until healing is complete.

The usual diet could be given from the second day of the operation onwards and is preferable to the milk diet commonly advised.

*Anæsthesia.*—General anaesthesia is generally used in rectal surgery. The anaesthesia should be deep and should be preceded by morphine-atropine injection to give the best results.

Two other methods of anaesthesia could be considered as they are free from any risk and of use in the absence of skilled help. These are sacral and regional anaesthesia.

*Sacral anæsthesia.*—The bony sacral canal is deficient posteriorly at its lower end and is closed by a membrane. This opening is called the sacral hiatus and is felt 1½" above the tip of the coccyx in the middle line. An ordinary hypodermic needle about 2" in length is pushed through the hiatus and as soon as it is felt to pierce the membrane, the butt of the needle is pushed downwards and the needle passed upwards parallel to the post surface of the sacrum. The needle should not pass too far upwards as it might pierce the dura, when the needle is in the correct position, the syringe is attached and about 40 to 90 c.c. of a 1 per cent

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solution of novocaine (with about 2 drops of adrenalin in 1000 to each 20 c.c.) is pushed in. This novocaine paralyses the sensory endings of all the nerves below the second sacral nerve and causes anaesthesia in the whole of the perineum, rectum and the neck of the bladder. This anaesthesia is sometimes unreliable and ·15 per cent. failures have been reported.

*Regional anaesthesia.*—In this, at the level of the tip of the coccyx on either side, on either side of the coccyx itself, into each ischiorectal fossa, on either side of the mid-line in front of the rectum and between the rectum and the prostate or the vagina injections of 1 per cent or ½ per cent novocaine are made as much as about 50 to 60 c.c. of a 1 per cent solution being used. The anaesthesia takes about 15 minutes to develop. Precaution must always be taken not to inject novocaine into a vein as toxic effects are always due to this.

Proceeding to the subject of this day, I am going to talk about piles, abscesses and fistulae, fissures and prolapse of the anus.

*Piles, External and Internal.*—External piles are recognised in three forms (*a*) a dilatation and varicosity of the anal veins causing a distinct swelling when the patient strains and leaving the skin loose when the patient ceases straining, (*b*) venous or thrombotic piles, due to a thrombus in a dilated vein or a haemotoma caused by the rupture of a vein during straining, the latter cause being more common as small, circular, ovoid swellings at the anal margin. Treatment is giving paraffin daily to soften the motions, prescribing hot hip baths twice daily and if necessary incising the overlying skin and clearing out the clots, (*c*) connective tissue external piles, loose folds of skin at the margin of the anus due to a fibrosed thrombosed pile or they may be at the lower margin of a fissure, in which case they are called sentinel piles. Treating the causal constipation and snipping these piles often results in cure.

*Internal piles.*—Bleeding, prolapse, pruritus frequently and a marked type of neurosis rarely are a few of the symptoms of piles. The bleeding occurs during defaecation, and more when the bowels are constipated and may at times be so severe as to cause a marked degree of anaemia. Inspection might show prolapse of the piles in advanced cases. Digital examination, unless when the piles are thrombosed and very much fibrosed reveals nothing. Confirmation might be secured by a speculum examination.

In strangulated piles, a common complication, very great pain is felt, a little temperature might be present, and on examination a dusky, congested swelling of several prolapsed piles is seen at the anus. Hot hip baths and fomentations to the anus give relief and reduction must be effected after touching with cocaine and adrenalin. At times it is preferable to remove the piles straight away under general anaesthesia. Palliative treatment may be undertaken for mild cases in chronic cardiac disease and portal obstruction and in atheromatous old men where piles act as a safety valve and its removal has been followed by cerebral hæmorrhage. Olive oil or paraffin are used to relieve constipation, Hæmaemelis ointment or injections of cold water with 6 oz. rectal syringe night and morning cause an astringent effect and are pretty satisfactory for mild cases. Injections of piles with a solution of phenol in glycerine and water (phenol 48 m, glycerine oz. 2, Aq distil oz. 2) are useful except where there is prolapse. No anaesthesia is necessary, a speculum is placed in position and the piles are injected *in situ* preferably one at a

time and not more than two at any time. A bent needle is more satisfactory and is inserted into the base of the pile, 4 to 5 m. of the above solution being injected. Sclerosis of the pile takes place and another injection could be made a week later. The patient could go about his ordinary duties during treatment.

*Operative treatment.—The Ligature method.*—After anaesthetization and the lysol douche, the sphincter is slowly stretched with the fingers and the piles prolapsed. The apex of each pile is caught with a forceps. The forceps is drawn further out and to the base is applied a forceps so as to crush it and in the groove left a silk ligature is tied with the knot towards the bowel. When the pile is large it is better to transfix the base with a needle and thread and tied off in two haves. Excision of the pile is better not done. After the operation morphine suppositories are pushed in and a T bandage placed.

Mitchell's operation of excision is the operation of choice. After the base of the pile is crushed with a large artery forceps the upper portion of the pile is cut off and a continuous catgut suture is introduced including the forceps and the tissues at the base of the pile. The suture is tightened as the forceps is released and withdrawn. This suture arrests the bleeding and closes the wound completely.

The clamp and cautery is specially indicated in sloughing piles. The clamp is applied to the base of the pile in a line radiating from the centre of the anus and tightened and the projecting portion burnt off with a Paquelin's cautery at a red heat. The clamp is gradually released to be tightened if any hæmorrhage occurs, when the cautery is again applied. Secondary hæmorrhage is more common with this type of operation than with others.

Hæmorrhage, sepsis and fissures are the complications frequently met with after operation. When hæmorrhage the patient should be examined under an anæsthetic when possible, and the bleeding point looked for and ligatured. If this is not found possible, plugging of the rectum with gauze soaked in Liq. adrenalin hydrochloride or Tr. Benzoin Co., should be resorted to. Sepsis occurs very rarely when the operation is done carefully. The patient generally complains of painful swelling of the anus and purulent discharge. Hot hip baths and fomentations give relief. Fissure should always be thought of whenever painful defaecation is complained of, after a rectal operation. Ichthyol and glycerine (oz. 2 to an oz) could be applied locally to give relief.

*Abscesses and fistulae of the Rectum.*—Abscesses are much less common than fistulae, but are more important as they invariably precede the formation of the latter. The common varieties of abscess are (*a*) anal abscess, (*b*) ischiorectal abscess, (*c*) submucous abscess and (*d*) pelvirectal abscess.

The anal abscess is a subcutaneous swelling causing extreme pain and œdema of the surrounding parts and it is felt best when not pointing with one finger at the anal margin and another inside the rectum. These abscesses must be opened up thoroughly as soon as the diagnosis is made and not allowed to ripen as it is called as troublesome fistulae might result.

Ischiorectal abscess is generally of the pyogenic type and rarely is it due to tubercle. The patient complains of extreme pain of a throbbing character, discomfort on sitting and might have a definite temp erature and develop rigors towards the evenings. On examination,

considerable induration of the skin is present and when the abscess approaches the surface, a red blush of the skin is visible. Fluctuation might be difficult to elicit. These abscesses have to be opened as soon as they are recognised. • Curved incision parallel to the anal margin is made over the prominent part of the swelling and another is made at right angles to this, outwards well beyond the limits of the induration. Whatever the shape of the incision, free excision of the cutaneous margins of the abscess should be performed and a large open wound left so that drainage might be free. Even if these abscesses have already opened into the rectum, it is best never to extend the incision to the rectum at this stage, as otherwise a very big wound is left leading into the rectum. When the abscess has healed, the fistula could be easily operated.

Submucous and pelvirectal abscesses are, the former between the internal sphincter and the mucous membrane of the rectum and the latter between the levator ani and the internal sphincter, however pretty rare. The former causes painful defaecation and digital examination might reveal the swelling, the incision being made either from inside or better on the skin outside close to the anus. For pelvirectal abscesses, causing a painful swelling high up on one side of the rectum an incision behind the anus might suffice. Fistulae in ano is a term loosely applied to suppurating tracks in the neighbourhood of the anus and lower end of the rectum. Some of them are only sinuses either opening into the skin or into the rectum only and incorrectly called external blind fistulae and internal blind fistulae respectively. The history of the formation of a fistula is thus:—a small tear or an ulcer near the region of the line of Hilton gets infected, the submucous layer in the neighbourhood is involved and an abscess forms which spreads out into the areolar tissue of the neighbourhood. The areolar tissue in the ischiorectal fossa being continuous with the subcutaneous fat, the infection spreads there too. When this abscess bursts of itself either into the skin or into the bowel or into both a fistula forms, defective drainage still persists and a pocket of the former abscess grows and bursting in another place forms another fistula and so on.

The simplest type of fistula is due to the bursting of an anal abscess. The openings are on one side of the anus with the internal opening just opposite to it on the anal margin, the track being straight, superficial and not more than 1½" in length.

Even in fistulae with multiple external openings (extending to 5 or 6 external openings) the internal opening is generally one and situated most often posteriorly on one side of the middle line. The internal opening is situated in the majority of cases superficial to the external sphincter and only rarely between the internal and external sphincter.

Horse shoe fistula is another not uncommon variety. In this type, the internal opening is situated posteriorly in the middle line and the external openings are on either side of the middle line communicating by a track behind the anus. Rarely these tracks are placed anterior to the anus with an internal opening in the anterior part of the anus..

The external opening of a fistula is generally quite small, and appears as a button shaped granulation or alike a little depression on the skin. This opening discharges a certain amount of more or less constant discharge. At intervals of a week or month, this part becomes very painful for a day or two, this is followed by a copious discharge

after which the pain subsides. Scars of previous operations are present in a large percentage of cases of fistula.

*Tubercle and fistulæ.*—Only 14 per cent of fistulæ were found to be tubercular in England and in India, I think the proportion is much less. The former idea that fistulæ were mainly tubercular in nature arose because of the bad treatment and consequent non-healing of the fistulæ.

*Treatment.—Non-operative.*—Injections of 2½ per cent solution of $AgNO_3$ repeated every two days could be tried, although at times sloughing of the tissues has taken place. Injection of Bismuth paste (Bisubnitrate oz. 1 and vaseline oz. 2) while in the liquid state is much safer and at times might be useful.

Operation is much the best method of treatment, the classical method being incision of the fistulous track and leaving the wound open. In a simple fistula, when the track is straight a probe is passed, the tissues overlying it incised, granulation tissue is thoroughly curetted and the edges cut away so as to leave an open wound

In the more extensive or the horse-shoe type of fistula, all the external tracks are slit up, the overhanging edges, freely removed, and finally the track leading into the bowel is incised. This incision must be radial to the anal margin as otherwise healing does not occur properly and incontinence might follow. In horse shoe type of fistula, when the wound behind the anus is very big, it is wiser to make the incision of the track leading to the bowel, a little later when the wound has healed up, as at the earlier stage the external sphincter has very little support and the posterior anal margin may be distorted. In internal blind fistula, where the internal opening is made out from a speculum examination and in external blind fistulæ when the probe passes near the anus, the fistula are made complete by cutting them into the skin and mucous membrane respectively and treated in the usual way. In some cases of external blind fistulæ or cutaneous sinus, several sinuses communicate with the skin and they all lead to an abscess underneath the skin and these fistula have no connection at all with the rectum. In such cases the opening up of the sinuses leaving an open wound causes healing.

Before completing an operation for fistula, the wound is mopped, any bleeding points ligatured if necessary and side tracks looked for. These are generally seen as dark holes lined by granulation tissue into which a director may be made to enter, and if present, they are to be opened up Finally the wound is plugged with gauze and a T bandage placed.

In the after treatment, this gauze is not removed for the first three days. From the second day onwards hot fomentations are applied two or three times daily. On the third or fourth day and afterwards until healing is complete after the usual aperient, hot hip baths are ordered and as the dressings soak out, fresh dressings are ordered. Healing generally takes about three to four weeks. The after-treatment is of much more importance in the case of a fistula than the operation itself and badly managed leads to recurrences.

Three points are to be stressed in operations for fistula. Firstly, all tracks must be opened up especially the track leading to the bowel, as this is the one generally missed and later causes trouble. Secondly the external sphincter must never be cut in two places even though there are two internal openings which is very rare, as incontinence is sure to follow.

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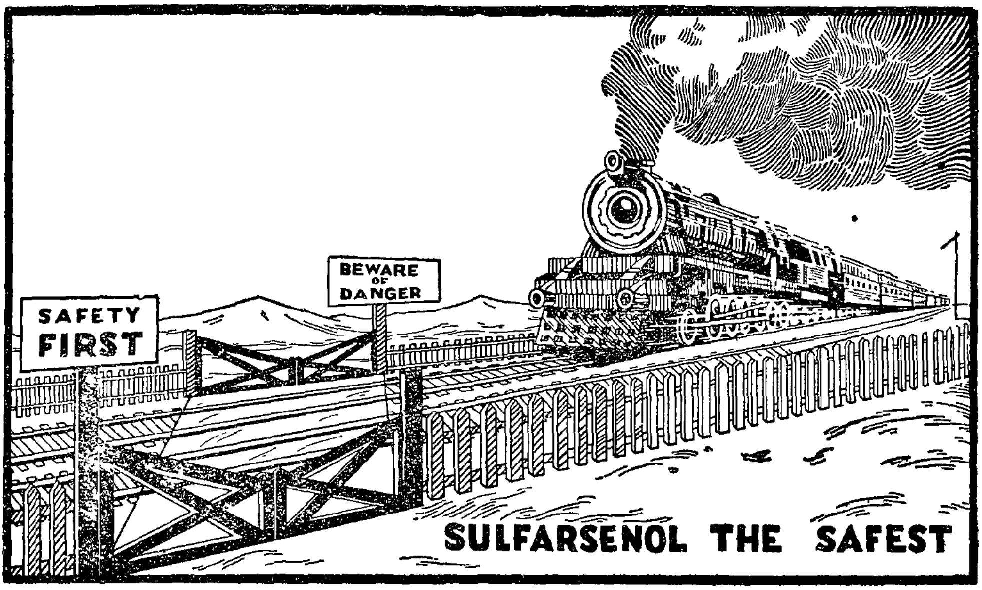


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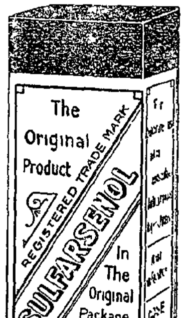


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Thirdly, the patient should be kept in bed as far as possible, until healing takes place, so as to allow the scar to get firm before it is subjected to much movement and healing is quicker with the patient resting.

*Prolapse of the anus* is a very common feature in childhood, although it is met with at all periods of life. It generally follows an exhausting illness, or a protracted diarrhœa or dysentery, when the patient is externally debilitated and an associated phimosis or bronchitis might aggravate the condition.

In the early stages, an exaggeration of the normal protrusion of mucous membrane accompanying the final act of defaecation is present. This progresses until the prolapse forms a conical projection, varying in length from 2 to 5 or 6 inches. The protruded mucous membrane shows a series of circular folds and at first is of a bright red colour; later if grasped by the sphincter it may appear blue and if it remains for a long time outside becomes paler in colour so as to resemble skin. Ulcers form over the surface at times and sloughing might occur occasionally.

*Treatment.—Palliative.*—The pelvis is raised and if necessary the child may be held up by the heels, the protrusion is smeared with vaseline and applying gentle pressure over the apex of the cone, the prolapse is reduced. After reduction, a soft pad is placed between the nates and a T bandage tied on to secure it in position; causes of straining as bronchitis, constipation and phimosis should be removed and the child should be made to defaecate when lying on the side. Injections of cold water or alum lotion might be useful at times. Operative measures are rarely indicated in children. Longitudinal cauterisations of the mucous membrane from base to apex of the prolapse, with a thermocautery, at four or five places all round, might be necessary in some cases. Serious pelvirectal inflammation might occur if the cauterisation is too deep. Excision of a V shaped piece of the mucous membrane posteriorly and if necessary anteriorly and subsequent closure of the wound with catgut sutures is more reliable than the cauterisation. In the case of prolapsed piles, Whitehead's excision in which the whole of the pile bearing area (1″ of mucous membrane above the line of Hilton) is excised and the mucous membrane above is stitched to the skin below, is suitable although stricture and frequently incontinence are serious drawbacks.

Anal fissure most commonly is an affection of adult life and can be defined as an elongated narrow ulcer in the long axis of the anal canal This ulcer is generally pear shaped in form, with the broad end towards the anal margin at the level of the lower margin of the external sphincter and the narrow end at the lower margin of the internal sphincter. The fissure is generally situated between the normal rugae of the anal orifice and ordinarily found at the posterior part of the anus and occasionally at the anterior end, these being the two portions which have less support than the lateral margins. There is generally an oedematous tag of skin at the lower end of the fissure, termed the "Sentinel Pile," which has led to the supposition that fissures are due to the tearing of one of the anal valves of Morgagni. A fissure is usually single and when multiple syphilis must be thought of.

The main symptom of a fissure is pain—and pain of a most intense character during and after defaecation lasting sometimes for an hour after. Reflex genito-urinary symptoms are met in women. A few drops of pus or even blood might exude during

defaection. Inspection shows on gently separating the anal folds the fissure.

*Treatment.* — Non-operative measures might be successful in fissures placed laterally or anteriorly, in those of recent occurrence and in those which are not complicated by piles or fistulae. Local applications of ichthyol and glycerine 20 per cent strength daily are about the best. Cocaine ointment (10gr. to an oz.) might be necessaiy when the pain is very severe. Liquid paraffin and frequent warm hot hip baths before and after defaecation will be useful.

*Operative treatment.*—The sphincter is carefully stretched after the usual preliminaries as anaesthetization, etc. An incision is made starting from the upper end of the fissure downwards and well beyond the anal margin. The base of the ulcer could be scraped away and the sentinel pile when present should be cut off. The edges of the wound have to be cut away so that a flat wound, is left and not a slit like opening. The portion of the wound on the skin could be considerably larger than the one inside the anal canal so that drainage might be effective. Aftertreatment is conducted in the same way as for fistulae.

Excision of the fissure, *i.e.*, the fibrous base of the fissure is completely removed in one mass, could be performed when the fissure is superficial. Care must always be taken to see that the external sphincter is not destroyed.

Ladies and Gentlemen, I thank you for your patient hearing. The only apology, I could give for the choice of this evening's subject is the great frequency of rectal conditions in general practice, and the varying degree of skill with which they are usually handled medically and surgically. In fine, I would feel highly gratified if I have brought home the importance of rational proctology.

## Intracranial Complication in chronic Middle Ear Suppuration— Ophthalmic findings suggesting its Existence—Report of Cases.

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The object of this report is to show that considering the time-honoured expression " that when a brain abscess is recognised it is too late to operate ", we do come across with cases in which remote facts in etiology, slender diagnostic indications and ophthalmoscopic findings justify a major brain abscess surgery. " Hundreds of patients live patiently with a chronic intermittent discharging otitis media the very chronicity of which has bred a resentment to interference. Now and then one insidiously develops an intracranial lesion but the diagnostic indication of this may be hopelessly obscure and might almost be described as an ' aura of impending trouble.' Doubtless many of us sorrow in the recollection of failure to interpret this incubation stage." That this has been the experience of the writer is the real purpose in recording these cases.

*Case 1.* Patient S., a tall well made student of 16 years was placed under my care in August 1929 for radical cure of chronic middle ear suppuration of right ear of more than ten years standing. Beyond the inconvenience of intermittent discharge and slight deafness, the patient had no pain or discomfort in the ear, no tenderness or pain or swelling over mastoid at any time of this long continued sepsis in the right ear. There was no rise of temperature that could be attributed to it. But he complained often of a temporal headache on the same side. He had also been suffering from trachoma and corneal ulcers in both eyes for which he was for a long time under the treatment of an Eye Surgeon. He had about him an appearance of lassitude,

general dullness of intellect and inability to attend to studies for sometime before he came to me for treatment. Middle ear of the affected side showed longstanding bone disease, drumhead and ossicles were absent, there were no polipi. As there was no history or evidence of chronic mastoiditis, no X ray picture was taken. There was deafness for low pitched sounds and intermittent tinnitus. His adenoids were removed, tonsils enucleated. Different methods of antiseptic treatment and ionic medication were tried with little or no benefit.

In the meanwhile one day the following symptoms of eye were observed : (1) the right palpebral fissure was narrower than the left (Ptosis), (2) circumcorneal injection in the right eye (3) slight inequality of pupils, (4) occasional indefinite pains in the orbit. This led to a suspicion of the possibility of existence of intracranial complications. But on such a slight diagnostic indication the writer was unable to suggest an exploratory mastoid operation. Neither the parents of the patient were prepared for it, as they attributed the headache and eye condition to trachoma and its compli cations; nor was any ophthalmoscopic examination made at the time. Probably a view of the fundus at the time could have exhibited the signs of the existence of intracranial complications.

The boy attending school was seen by me at longer intervals. At each time I saw I had a suspicion of impending trouble. But, as these symptoms appeared stationary and as there was no impairment of vision even after a long time I thought my suspicion was not justified.

Suddenly one day in December 1929 he was brought to me in a state of complete stupor with meningeal symptoms, high temperature, rapid pulse, rigidity of muscles of neck, loss of reflexes on the left side of the body and dilated pupils. An immediate operation was advised but the patient's father waited for his doctor brother from a distant mofussil station. So, much time was lost and the case ended fatally.

*Case 2.*—In this case though diagnostic indications and ophthalmic findings were as slender as in the former, surgical interference in time saved the life of the patient.

Raman, male, 9 years, with an ill-nourished feeble constitution. His father died of tuberculosis of the lungs. Discharging right ear of 7 years duration. Discharge continuous, had an abscess behind the external ear which was opened at a local fund dispensary, leaving a small scar but with no sinus. He was placed under my treatment in the first week of January 1931. There was a large marginal perforation in the outer and lower quadrant of right ear. Discharge purulent, thick and foul. Rise of temperature every evening to 101°. There was no sagging in of posterior superior wall, no pain or tenderness or swelling over mastoid. Patient complained of temporal headache and pain in the right orbit. Although history of the swelling behind the ear suggested an attack of Mastoiditis there was nothing to suggest the existence of suppuration in the mastoid. There was nothing abnormal except the evening rise of temperature. In a few days these eye symptoms were noticed. (1) Ptosis, (2) Conjunctival redness of right eye, (3) Slight inequality of pupils, (4) Ophthalmoscopic examination revealed retinal veins full and tortuous, fundus slightly oedematous and hazy. An immediate exploratory operation was urged. The operation was delayed by relatives of

the patient. On the 15th January patient complained of dimness of vision in right eye. Pressure on 2nd and 3rd nerve and cavernous sinus by tempero-sphenoidal abscess was suspected. Patient was operated immediately. On exposing the mastoid antrum a large self dissected abscess cavity was found with cholesteomatous masses. While curetting this cavity and the still unopened mastoid cells at the lower part it was found that the bony wall of lateral sinus was necrosed exposing the vertical limb of the sinus which was found in this case to be unusually superficial. While carefully curetting the necrosed wall lateral sinus itself evidently under great pressure bulged into the cavity pulsating synchronously with breathing. On lifting the lateral sinus by a director seropurulent fluid escaped from between sinus and bony wall and an extradural abscess was found. Eye symptoms were found to be due to pressure of this abscess on lateral sinus extending up to Cavernous sinus and the structures entering the orbit. The lateral sinus itself looked healthy It was pulsating and permeable to circulation. There was no evidence of phlebitis or thrombosis of lateral sinus. After establishing perfect drainage for the extradural abscess further steps of radical mastoid were quickly done. It was found that the self dissected cavity of antrum was freely draining its contents through a wide auditus adantrum into middle ear and so the cleansing of middle ear and its granulations was easy. The cavity was drained through a retroauricular mastoid wound.

For three days the patient was in a bad condition, temperature ranging from 102 to 103°. There was profuse discharge and the lateral sinus was seen pulsating. Slowly it receded to its position. Headache and eye symptoms gradually disappeared. Patient had an uneventful recovery. Middle ear is dry.

CONCLUSIONS.

1. Persistent headache in a case of chronic discharging ear, which does not improve with the usual remedies should always be considered seriously as a warning of the impending if not actually existing intracranial infection.

2. Lay public do not take any serious notice of chronic middle ear suppuration. They regard running of ears as an innocent affair. Though in many cases running of ears do disappear at a later stage of life they leave behind sclerotic changes in petrous bone leading to deafness.

3. Middle ear sepsis in children is amenable to treatment before sepsis involves the bone. It is the duty of internists to bring to the notice of their parents the seriousness of a middle ear suppuration, *viz.*, nearness of the middle ear sepsis to brain cavity and the probability of grave complications occurring suddenly and without warning in some of these cases.

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